Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

IOWA DENTAL BOARD
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

Enclosed is the application for dental assistant registration and radiography qualification. Dental assistant trainees and graduates may now apply for registration and radiography qualification on one form, with the non-refundable fee of $40. To do so, you must have received board-approved clinical training in dental radiography and have passed the radiography exam. If you meet the requirements and would like to obtain your radiography qualification, answer "yes" to question four, in section two of the application. Keep in mind that you must meet all of the requirements and attach all necessary documentation to receive the qualification in dental radiography.

If you do not meet the radiography requirements at the time of initial registration, you have two years following training to complete the requirements for radiography qualification. **Be advised, however, if you do not apply for radiography qualification at the time of registration, you must later submit a separate application and pay a separate fee of $40 for processing an additional application for qualification in dental radiography.** The board strongly suggests that you make every effort to complete the radiography requirements for issuance of your radiography qualification at the time of registration.

Please allow a minimum of 14 days for your application to be processed. The board office will contact you if additional information is required to complete your application. Please be advised that you should contact the board office at least 30 days prior to your trainee expiration date if you have any medical condition that might impair your ability to practice the profession or any criminal history that could affect registration. These issues can delay registration.

To submit a complete application, please make sure to:

- Answer all questions completely and ensure that all information is correct. Attach all necessary documentation.
- Include the $40 fee with your application. This fee is non-refundable. Submit payment in the form of a check or money order. Do not send cash!
- If you are making application for qualification in dental radiography, answer "yes" to question four, on page 1 of the application. If you were on trainee status, make sure that the supervising dentist verifies your training in dental radiography on the affidavit of employment.
- Attach copies of score reports for all exams. The board accepts the board exams or the Dental Assisting National Board (DANB) exams in infection control taken after June 1991 and radiography taken after January 1986.
- Have your supervising dentist complete and submit the affidavit of employment, or have your post-secondary school complete and submit the certification of dental assisting education, as appropriate.
- Request verification from each state in which you have been licensed, registered or certified as a dental assistant.
- Provide a separate, signed statement for any "yes" responses to questions 1 – 15 in section 5. Please be thorough when submitting this additional information. If you answered "yes" to question 5, the board may request that you supply a certified copy of your Iowa criminal history and other relevant court documents.
- Read the affidavit of applicant carefully. Your signature must be notarized.
- Attach a copy of a current CPR card.
- Attach a recent photograph.

If you are unable to include all relevant information when you submit the application, please attach a note indicating when to expect this information.

APPLICATION FOR IOWA DENTAL ASSISTANT REGISTRATION AND RADIOGRAPHY QUALIFICATION

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Ph. (515) 281-5157; http://www.dentalboard.iowa.gov

Complete each question on the application. If not applicable, mark "n/a". Submit the **non-refundable** application fee of $40, made payable to the Iowa Dental Board, with this application. Do not send cash!

1. IDENTIFYING INFORMATION

Full Legal Name: (First, Middle, Last)					
Other Last Names Used: (e.g. Maiden, other married names)			Email Address:		
Home Address:					
City:	County:	State:	Zip Code:		
Work Address:					
City:	County:	State:	Zip Code:		
Home Phone:	Home Fax:	Work Phone:	Work Fax:		
Social Security Number:	**Privacy Act Notice:** Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13), Iowa Code §§ 272J.8(1) and 261.126(1), and Iowa Code § 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.				
Height:	Weight:	Hair Color:	Eye Color:		
Identifying Marks:	Gender: Female: ☐ Male: ☐	U.S. Citizen: Yes: ☐ No: ☐	If no, Visa Type or Alien Registration Number:		
Date of Birth:	City of Birth:	State of Birth:	Country of Birth:		
Father's Full Name:		Mother's Full Name:			
Full Name & Address of Nearest Relative Not Living With You:			Phone:		
Name of High School:	City:	State:	From: (Mo, Yr.)	To: (Mo, Yr)	Diploma ☐ GED ☐
Name of College:	City:	State:	From: (Mo, Yr.)	To: (Mo, Yr)	Type of Degree:
Name of College:	City:	State:	From: (Mo, Yr.)	To: (Mo, Yr)	Type of Degree:

2. BASIS FOR APPLICATION

1. I have worked in a dental office for a minimum of six months as a dental assistant trainee.* YES ☐ NO ☐
   Trainee Number_____ *Complete Affidavit of Employment.
2. I have at least six months of prior dental assisting experience under the supervision of a licensed dentist within the past two years. *Complete Affidavit of Employment. YES ☐ NO ☐
3. I am a graduate of a postsecondary dental assisting program.** YES ☐ NO ☐
   Name of school:_____ **Complete Certification of Education.
4. I have passed an exam in dental radiography and am also applying for radiography qualification. YES ☐ NO ☐

Office Use:	Reg. #	Aff. Employment:	Fee:	ICE Exam:	Juris:
	Date:	Cert. Education:	CPR:	RAD Exam:	RAD Train:

Name of Applicant _____

3. QUALIFICATIONS & EXPERIENCE

1. Do you currently take dental x-rays in Iowa? YES ☐ NO ☐

2. Do you now have, or have you ever held, a certificate of qualification in dental radiology issued by the Iowa Dental Board? YES ☐ NO ☐
   If yes, what is the qualification number? _____

3. Did you complete a course of study using the study manual or other course approved by the board in the area of dental radiology? YES ☐ NO ☐

4. Did you complete clinical (i.e. on-the-job) dental radiology training under the supervision of a dentist? If yes, the supervising dentist must verify this training on the Affidavit of Employment. YES ☐ NO ☐

5. Did you successfully complete the board-approved radiology exam or Dental Assisting National Board radiology exam?* (DANB radiology exam must have been completed after January 1986.) YES ☐ NO ☐
   Date completed _____ *Attach copy of scores.

6. Did you complete a course of study approved by the board in the areas of infection control/hazardous materials and jurisprudence using the study manual or at a board-approved post-secondary school (i.e. community college)? YES ☐ NO ☐

7. Did you successfully complete the Iowa dental assistant jurisprudence exam? YES ☐ NO ☐
   Date completed _____ *Attach copy of scores.

8. Did you successfully complete the board-approved exam in infection control/ hazardous materials or the Dental Assisting National Board infection control exam (ICE)?* (DANB ICE must have been completed after June 1991.) YES ☐ NO ☐
   Date completed _____ *Attach copy of scores.

9. Have you ever passed any of the Dental Assisting National Board exams? YES ☐ NO ☐
   If yes, which one(s)_____

10. Are you currently certified in cardiopulmonary resuscitation by a nationally-recognized provider? * Attach copy of CPR card. YES ☐ NO ☐

11. Are you registered, certified, or qualified as a dental assistant in another state? YES ☐ NO ☐
    If yes, which state(s) and type of qualification_____
    *If yes, request that a written verification from the state board be sent to this board office.

12. Provide a chronological listing of all dental related employment in the last five years. Include months, years, location (city and state), and type of work. Attach a separate sheet if necessary.

Employer Dentist Name & Location	Type of Work (e.g. Chairside, Lab, Office)	From (Mo, Yr):	To (Mo, Yr):	Hours per week

Name of Applicant _____

4. DEFINITIONS

Important! Read these definitions before completing the following questions.

"Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

"Improper use of drugs or other chemical substances" means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

SECTION 5. In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 15, YOU MUST PROVIDE A SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

YES	NO		
☐	☐	1.	Do you currently have a medical condition that in any way impairs or limits your ability to practice dental assisting with reasonable skill and safety?
☐	☐	2.	Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
☐	☐	3.	Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dental assisting with reasonable skill and safety?
☐	☐	4.	If yes to questions 1 to 3, are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
☐	☐	5.	Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?
☐	☐	6.	Have you ever been terminated or requested to withdraw from any dental assisting school or training program?
☐	☐	7.	Have you ever been requested to repeat a portion of any dental assisting training program/school?
☐	☐	8.	Have you ever received a warning, reprimand, or been placed on probation during a dental assisting training program/school?
☐	☐	9.	Have you ever been denied a registration/certificate to practice dental assisting?
☐	☐	10.	Have you ever voluntarily surrendered a registration/certification issued to you by any professional licensing agency?
☐	☐	11.	If yes, was license/registration disciplinary action pending against you, or were you under investigation by a licensing agency at the time the voluntary surrender of license/registration was tendered?

Name of Applicant _____

YES NO

☐ ☐ 12. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dental assisting?

☐ ☐ 13. Are charges or an investigation currently pending relative to your license/registration in any other state?

☐ ☐ 14. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license/registration you held?

☐ ☐ 15. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?

☐ ☐ 16. Do you understand that if registration is granted by this board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the registration?

6. AFFIDAVIT OF APPLICANT

STATE OF _____ COUNTY OF _____

I, _____, hereby declare under penalty of perjury that I am the person described and identified in this application and that the attached photograph is a true likeness of myself. I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

If registration is issued to me, I understand that if I violate state law, my registration may be revoked as provided by law. I declare under penalty of perjury that my answers and all statements made by me on this application are true and correct. Should I furnish any false information or have substantial omission in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my registration.

I hereby authorize the Iowa Dental Board and/or its agents to verify any information including, but not limited to, criminal history and motor vehicle driving records. I authorize all colleges or universities, employers and law enforcement agencies to release any information concerning my background to the Iowa Dental Board for registration purposes. I do hereby release said person(s) from any and all liability that may be incurred as a result of furnishing such information. A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

Applicant's Signature (full name) _____

Sworn to before me this _____ day of _____ ,_____

Notary Public Signature_____

My Commission Expires_____(Notary Seal)

Attach

Photograph

Here

Attach

Current CPR Card

Here

CERTIFICATION OF DENTAL ASSISTING EDUCATION

As part of the application process, the Iowa Dental Board requires that the school at which the applicant received her/his dental assisting education complete this form. The completed form must be mailed directly from the school to the **IOWA DENTAL BOARD.** Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name _____ SS# _____

Signature _____ Date _____

The dental assisting school should complete this portion of the form.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

RECEIVED DENTAL ASSISTING EDUCATION AT _____
(Name of School)

LOCATED AT _____
(Full Address of School)

FROM _____ TO _____
(Month/Year) (Month/Year)

GRANTED A DIPLOMA WITH THE DEGREE OF _____

DATE DIPLOMA RECEIVED _____
(Month/Year)

Was the school accredited by the Commission on Dental Accreditation of the American Dental Association at the time the applicant graduated? Yes: _____ No: _____

SCHOOL SEAL

President, Dean, Secretary, or Registrar:

Print Name _____ Title _____

Signature _____ Date _____

Phone # _____ Fax # _____

Return Completed Form to:

IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157

AFFIDAVIT OF EMPLOYMENT

The dental assistant's supervising dentist should complete this form.

Applicants for dental assistant registration who are not graduates of a postsecondary dental assisting program must either (1) work in a dental office for a minimum of six months as a dental assistant trainee or (2) have had at least six months of prior dental assisting experience under the supervision of a licensed dentist within the past two years. To verify that the dental assistant meets one of these requirements, the supervising dentist must complete and sign the following form.

I hereby certify that the applicant, _____, has successfully completed didactic and clinical training and has worked as a dental assistant under my supervision on the following dates at the following locations:

Date: **Location:**

_____

_____

_____

YES ☐ **NO** ☐ I further certify that the applicant has received clinical training in dental radiography and has exhibited clinical proficiency in the area of dental radiography.

_____ _____

Printed Name of Dentist License #

_____ _____

Dentist's Signature Date

Return Completed Form to:

IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157